DEVELOPMENTAL HISTORY

Name of Minor Client:_____

Nickname?_____

Date of Birth:	Grade:	Gender: (circle) M F	
Address:			
Street	City	State	Zip
Phone: (H)	Okay to Leave Message?	YES	NO
(C)	Okay to Leave Message?	YES	NO
(Other)	Okay to Leave Message?	YES	NO
School:			
Teacher(s):			

Mother/Parent A

Name:	Date of Birth:
Address:	
Phone:	
Occupation:	

Father/Parent B

Name:	Date of Birth:
Address:	
Phone:	
Occupation:	

Marital Status of Parents:

☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

How long married?_____ How long divorced?_____ Child's age at divorce_____

If parents are divorced, separated, or single who has legal custody of the child?

☐ Mother/Parent A ☐ Father/Parent B ☐ Mother/Parent A and Father/Parent B

☐ Other _____

What are your primary concerns about your child?

_____

_____

_____

Please describe your child's strengths and interests:

_____

_____

_____

DEVELOPMENTAL HISTORY

Previous Evaluations (Psychiatric, Psychological, Educational, Speech/Language, Occupational Therapy, etc.):

Name of Provider	Type as Assessment/Treatment	Dates of Services

Medical History/Status/Concerns:

Condition/Concern	YES/NO	If yes, please specify details:
Any Diagnoses (i.e., ADHD, anxiety disorder, mood disorder, etc.)	YES NO	
Hospitalizations	YES NO	
Head Injuries	YES NO	
Chronic Medical Conditions (i.e., asthma, ear infections, etc.)	YES NO	
Allergies	YES NO	
Current Medical Concerns	YES NO	
Is your child on any medications CURRENTLY?	YES NO	

Family History of Medical/Psychological Conditions (Please Check)

Condition	**Mother**	**Father**	**Sibling(s)**	**Others**
ADHD				
Anxiety				
Depression				
Behavior Problems				
Learning Disabilities				
Drugs/Alcohol				
Psychiatric Hospitalizations				

Educational History

Has your child ever been retained for a grade? YES NO

If yes, which grade? _____

Does your child receive any special educational services?

If yes, please describe:

_____

_____

DEVELOPMENTAL HISTORY

Does your child have a 504 Plan? YES NO
If yes, please describe:

_____
_____

Does your child receive any private tutorial services? YES NO
If yes, please list:

NAME	TYPE OF TUTOR

Developmental History
Birth: _____ weeks

Birth Complications?

_____
_____

Pregnancy Complications?

_____
_____

Substance Use During Pregnancy? YES NO
If yes, please check:

☐ Cigarettes ☐ Alcohol ☐ Drug(s) _____

Any concerns regarding meeting developmental milestones?
Gross Motor: _____
Fine Motor: _____
Language Development: _____
Potty Training: _____

Name of person completing this form:

_____ Date: _____